Children's Special Health Services

Financial Assistance Application
PO Box 202951 - Helena, MT 59620
Phone: 1-800-762-9891
Fax 406-444-2750

Children's Special Health Services can provide up to $2,000 per year of financial assistance for treatment and enabling services for qualifying children and youth with special healthcare needs (CYSHCN).
A child or youth with special health care needs is under the age of 22 and has or *is at increased risk* for a chronic physical, developmental, behavioral, or emotional condition *and* also requires health and related services of a type or amount beyond that required by children generally.
Please complete and sign this application and provide the following documentation:

1. The most recent tax returns for each person in the household who earns income (not required if under the age of 19 *and* attending school).
2. A copy of the child's insurance card (front and back, must be readable).
3. ***If*** you are requesting assistance with a medical treatment or expense, you must provide documentation that you do not qualify for Healthy Montana Kids (Children's Health Insurance Program).

SECTION 1: Applicant & Family Information
This section may be completed by the family or a designee

Applicants Name:_____ DOB: _____

Main Phone:_____ Alternate Phone: _____

Mailing Address (for correspondence):_____

City:_____ State:_____ Zip:_____

Parent or Guardian Name:_____

Parent or Guardian Name:_____

Please indicate how many individuals:

Live in the Household:_____

Earn Income (do not count if under 19 *and* attending school):_____

Receive Dependent Care Services so the child's guardian can work, look for work, or attend school. Example: Daycare, pre-schools, babysitter, etc.:_____

SECTION 2: Qualifying Condition Information:
*Note: Complete **Either** A. or B. below. If Section A. is completed, it must be signed by a medical provider licensed in the state of Montana. If Section B. is completed it must be signed by a health or family support worker such as a case manager, nurse, social worker, home visitor, etc.*

A. Use this section if you are requesting financial assistance because the child or youth **has a** chronic physical, developmental, behavioral, or emotional condition **and also** requires health and related services of a type or amount beyond that required by children generally.

Medical Information:
This information must be about the condition for which the applicant is requesting assistance.

Medical Diagnosis: _____ICD-10 Code (required):_____

Please briefly explain how/why this child or youth uses health and related services of a type or amount beyond that required by children generally:

I attest the medical diagnosis of the applicant listed above is true and accurate:

_____ _____
Medical Provider Signature Date

B. Use this section if you are requesting financial assistance because the child or youth **is at increased risk for** chronic physical, developmental, behavioral, or emotional condition **and also** requires health and related services of a type or amount beyond that required by children generally.

This information must be about the condition for which the applicant is requesting assistance.

Please briefly explain how/why this child or youth is at increased risk for a chronic physical, developmental, behavioral, or emotional condition **and how/why** he or she requires health and related services of a type or amount beyond that required by children generally:

I attest the risk condition(s) of the applicant explained above are true and accurate:

_____ _____
Health or Family Support Professional Signature Date

SECTION 3: Financial Assistance Request Information

This Section must be completed by a MEDICAL PROVIDER or HEALTH or FAMILY SUPPORT PROFESSIONAL (e.g. Case Manager, Nurse, Social Worker, Community Health Worker)

Note: This form is to be completed for each service for which the applicant is requesting financial assistance. If you are requesting financial assistance for more than one service, you may print additional copies of this page. The annual limit for financial assistance is $2,000 per qualifying child/youth.

Is the service for which the applicant is requesting financial aid considered an "enabling service" (e.g. case management, care coordination, referrals, home visiting, respite care, specialized daycare or preschool, translation/interpretation, transportation, eligibility assistance, health education for individuals or families, outreach, other)?

- ☐ No
- ☐ Yes. Please explain the enabling service:

Actual or estimated cost of the service: _____

Is the service for which the applicant is requesting financial aid considered "treatment" which has the potential to improve the applicant's outcomes (ex: medical, corrective, surgical intervention, medications, and/or medical equipment*)?

- ☐ No.
- ☐ Yes. Please explain the treatment service and provide the CPT code if applicable:

Actual or estimated cost of the service: _____

For enabling and treatment service: Please provide the following information for provider, health organization, agency or business that will be receiving payment for the service: (ex: medical provider, durable medical equipment provider, pharmacist, dentist, orthodontist, surgical center, health department, transportation provider, service providing agency)

Medical Provider/Professional Name: _____

Department/Business Name (if applicable): _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

_____

Initials Health/Family Support Provider or Medical Provider

Release of Information: I certify that the information I have given is true to the best of my knowledge. I give permission to the State of Montana to make any necessary contacts to check my statements. I agree all providers can release any medical, social and insurance information about my child to CSHS upon request in order to administer CSHS benefits. Once information is provided to CSHS, I hold the provider harmless for subsequent disclosures of this information by CSHS. If I knowingly give false information to enroll my child in CSHS, I understand that I must reimburse the State of Montana for any costs incurred, and benefits from CSHS will terminate. This release is effective for 18 months from date signed.

Revocation Statement: I understand I have the right to revoke the above authorization for the release of information at any time by contacting CSHS. Children's Special Health Services, PO Box 202951, Helena MT 59620, 1-800-762-9891.

PARENT or LEGAL GUARDIAN SIGNATURE Date

*****If you are requesting assistance to purchase medical equipment (e.g. Occupational Therapy items, learning aids, etc.) which will be purchased online, CSHS can make the purchase and have the item(s) mailed to your home. CSHS staff will contact you to make these arrangements.